

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

891-63-006297
STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No.

FILED FEB 26 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Frank Ellis

1. PLACE OF DEATH a. COUNTY Jackson,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital		d. STREET ADDRESS (If outside, give location) 3726 Indiana	
3. NAME OF DECEASED (Type or print) First <i>Inf</i> Last <i>Baker</i>		4. DATE OF DEATH Month January Day 18, Year 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-17-63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME Unnamed		11b. MOTHER'S MAIDEN NAME Jo Dell Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Jo Dell Baker	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <i>prematurity</i>		12. CITIZEN OF WHAT COUNTRY USA	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		14. NAME OF HUSBAND OR WIFE —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-17-63 to 1-18-63 and last saw her alive on 1-18-63 Death occurred at 6:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>Frank Ellis</i> (Degree or title)	
22b. ADDRESS 2400 Cherry		22c. DATE SIGNED 2-4-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical		23b. DATE 1-18-63	
23c. NAME OF CEMETERY OR CREMATORY H.C. University		23d. LOCATION (City, town, or county) (State) Kansas City Mo.	
24. FUNERAL DIRECTOR Dr. J. E. Herdstein		25. DATE RECD. BY LOCAL REG. 2-11-63	
26. REGISTRAR'S SIGNATURE <i>Keith Long</i>			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.